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ORIGINAL DEPARTMENT.

LECTURE.

ON PULMONARY PHTHISIS.

Delivered at Bellevue Hospital, New York, May 23d, 1878.

BY PROF. AUSTIN FLINT, SR.

Reported Expressly for the MEDICAL AND SURGICAL REPORTER.

GENTLEMEN:—I propose, this morning, to engage with you in some brief studies on the subject of phthisis; and, in the first place, it would be well for us to inquire what is meant by this term. At the present time, as you are aware, there are many different expressions employed to denote different phases of it, and a variety of really different affections are included under it. Still, I doubt if there is any practical advantage in attempting to subdivide the subject minutely, and thus multiplying the number of terms which it is necessary to use in connection with it. I shall, therefore, confine myself, to-day, almost entirely to the consideration of what is ordinarily understood as the disease, pulmonary or pneumonic phthisis.

There is, I may remark, in passing, an affection which is not usually identified with this, and yet has certain characters in common with it, viz., acute miliary tuberculosis. In its main features, however, it differs widely from it; being characterized by an enormous deposit of tuberculous matter throughout the entire extent of both lungs, which produces the most profound effect upon the general system, and rapidly destroys life, on account of its mechanical interference with the function of respiration.

Then there is another form of disease which

is frequently embraced under the designation of phthisis, but which differs widely from what is ordinarily known as pneumonic phthisis, and that is, fibroid phthisis, or cirrhosis of the lung. A better name for it would be sclerosis of the lung, and I think it would be a great improvement to substitute the term sclerosis for cirrhosis when in any of the organs of the body there is, or has been, going on that form of inflammatory action which is attended by an abnormal development of cellular tissue.

Irrespective of these, however, we have a disease which, without going into any histological minutiae, we may say is characterized by a peculiar exudation,¹ ordinarily yellowish in color and of a cheesy consistence. This is tuberculous matter, and it may vary very greatly in quantity, mode of distribution, and some of its physical characteristics. It may accumulate to such an extent as to give rise to a considerable amount of consolidation in the lung, or it may collect in small masses; or, again, be quite widely disseminated in single tubercles. It shows a decided predilection for the upper part of the lungs, and though at first it ordinarily affects but one lung, later on it becomes developed in the other also. After a time it undergoes a process of softening, and at length becomes reduced to the form of a liquid. Accumulations of such fluid are then sometimes denominated tuberculous abscesses. In the great majority of instances they open into the bronchial tubes, and, as a result, we have emptying of their contents and the formation of cavities. More rarely they empty into the pleural sac. This is a brief sketch of the ordinary history of tubercle in the lung.

To-day I wish merely to call your attention to some points in reference to diagnosis and prognosis. From the symptoms above we cannot always decide, in any given case, whether phthisis exists or not, or, at all events, not with positive certainty. Ordinarily, where there is any doubt, the diagnosis lies between phthisis and chronic bronchitis, and it requires a physical explanation to show the true state of affairs. What, then, are some of the signs by which we may recognize tuberculous disease?

There is usually slight solidification at the apex of one lung, or, if on both sides of the chest, more marked in one lung than in the other. In forming an opinion of such a solidification we must, of course, always take into consideration the history of the case also; and, indeed, in most instances when the history points toward phthisis, it is not difficult to arrive at a correct diagnosis. The solidification of the pulmonary tissue is indicated by dullness on percussion, bronchial or bronchovesicular respiration, increased vocal resonance, or, perhaps, bronchophony, increased vocal fremitus, and exaggerated bronchial whisper. In judging of such signs you must remember that we ought not to neglect to make due allowance for the normal differences between the two sides of the chest. Of course, it is always a matter of great importance to the patient for us to determine whether, in any case, we can exclude phthisis, and, therefore, it should be our aim to become as familiar as we possibly can with the physical signs presented by the chest, both in health and disease. If, after a thorough explanation, we can find only evidences of chronic bronchitis, we can at once reassure our patient, for this is an affection of comparatively trifling seriousness, or, at all events, involving no immediate danger.

The signs of phthisis just alluded to are those characterizing the disease in the first stage, or before any cavities have been formed; the second stage is marked by the existence of one or more cavities, and when we suspect that the tuberculous trouble has gone on to this stage, we naturally look for cavernous signs. Among these are, cavernous respiration, amphoric respiration, gurgling, and amphoric voice and resonance on percussion.

This disease is interesting from various points of view, and one of the most interesting things in connection with it is the fact (on which I have not the time to dwell to-day) that

it naturally tends to recovery, or at least tends toward a point where it remains stationary in the system. This will, no doubt, strike some of you as being rather a novel view to take of consumption; but the more I see of the disease, the more convinced am I that this point is well substantiated. In treating cases of it, therefore, our aim should be the recovery of the patient, and if this desirable result cannot be accomplished, we should endeavor to render the disease no longer progressive. This morning, I saw, for the first time since last Autumn, a patient, who at that time gave distinct evidence of the existence of cavities in the lungs. From the fact of there being no appreciable solidification of the tissue surrounding the cavities, however, I came to the conclusion that the case had ceased to be progressive, and consequently gave rather a favorable prognosis. Much to my gratification, when I made an examination of the chest to-day, I found that all the signs of the cavities had disappeared. The latter had become so much reduced in size as to give rise to no further apprehension, and the patient was practically well.

Case 1.—*Hæmoptysis from Vicarious Menstruation.*

The first patient whom I shall bring before you is a woman, who has been troubled with one of the most frequent and characteristic symptoms of phthisis, viz., hæmoptysis; and yet in her, I think, we shall have to look for some other explanation of the phenomenon. She is a widow, twenty-six years of age, and her family history is good. Six months ago she began to have spitting of blood, at the same time that she had a slight uterine hemorrhage; and since that date she has continued to have hæmoptysis returning periodically with the menstrual flow, which has always been very small in quantity since then. Careful attention has been paid to the clinical history, and a very thorough examination of the chest has been made here; and both have resulted entirely negatively, so far as any other evidence of pulmonary tuberculosis is concerned. We are forced to the conclusion, therefore, that we have here one of those very rare cases in which hæmoptysis is really vicarious.

In phthisis, as you are aware, the menses at length disappear, and it is a common idea among such patients and their friends that if the menstrual function were only to be restored they would soon be all right again. But, of

course, the truth is that the suppression is solely dependent on the tubercular disease, instead of the symptoms noticed being at all attributable to the suppression. In hæmoptysis in women, when there are no other signs of phthisis present, we will always do well to inquire whether there is a periodicity about the hemorrhage; but cases of vicarious menstruation, like the present, are exceedingly rare, and I only remember seeing one other of the same character.

Case 2.—Fibroid Phthisis.

I have not much time to dwell upon the next case, but it presents several points of great interest in connection with our study to-day. The patient's name is Hester M. She is twenty years of age, and was admitted to the Hospital nearly a month ago. There is no history of phthisis in her family; but she says she commenced to cough about three months since, and that she has had two hemorrhages from the lungs. Since admission her cough has been very severe, and accompanied by free purulent expectoration. She has also had copious night sweats, which for a time resisted alum, atropia, and the use of baths, but are now controlled, to a great extent, by atropia. In addition, the temperature has been very high.

On making an examination of the chest we find evidences of solidification on the left side. Percussion here gives us just what is found in lobar pneumonia. There is vesiculo-tympanic resonance, high in pitch, at the apex of the left lung in part, while behind, on the same side, there is absolute flatness over the whole of the lower lobe. On auscultation at this part we get bronchial respiration, with moist râles. We infer, therefore, that this is a case of fibroid phthisis.

But why, it may be asked, do we call this fibroid phthisis? Why is it not ordinary pneumonic phthisis? To this we may reply that it differs from the latter in several respects. In the first place the trouble commenced in the lower, instead of the upper lobe of the lung, and secondly, it was, from the first, very extensive. Then, again, it persists without the symptoms and signs which denote softening of pneumonic products, and the formation of cavities. This inflammation of the fibrous tissue of the lung is very apt to give rise to shrinking of the organ, and enlargements of the bronchial tubes, which sometimes closely

resemble, and are quite liable to be mistaken for, cavities. In this patient there does not appear to be any clubbing of the fingers, but this is very frequently seen in cases of similar character.

This case illustrates in quite a striking manner the effect of quinia in reducing temperature. She has been taking twenty grains of the drug a day, fifteen grains being given her in the morning, and five grains again in the evening. During a period of ten days in which she took it regularly in this manner the temperature ranged from 100 to 102 degrees, while, when it was discontinued for a few days, it ranged from 101 to 104 degrees. On resuming the use of the remedy, however, the temperature again fell; this time ranging from 98 to 101 degrees, although on one single occasion it did run up as high as 103 degrees.

Case 3.—Tuberculosis of the Lungs; Formation of Cavities; Arrest of the Disease; Removal of its Products.

The next patient is Michael D., twenty-seven years of age, and there is no history of phthisis in his family, as far as can be ascertained. His cough began a year ago, and he had hæmoptysis for the first time about four months ago. This has been repeated several times since then; and I may say, in passing, that such hemorrhages always afford strong ground for the suspicion of phthisis. The man has also complained of lancinating pains on both sides of the chest, and these are undoubtedly due to the occurrence of dry pleurisy, which are almost invariably concomitants of phthisis. There has been considerable emaciation (the patient having lost thirty-five or forty pounds), and beside, febrile movement, with night-sweats. We have here a case, then, which presents several of the strong diagnostic points of phthisis; but still, for the positive demonstration of the disease, its characteristic physical signs are also required.

Let us see, therefore, if these signs are present here, and if so, endeavor to determine at what stage the affection has arrived. In commencing the examination I would call your attention, incidentally, to the fact that the man looks pretty well about the face, that his color is good, and that the emaciation is at present not at all marked. In connection with these circumstances, it is interesting to note that the exploration of the chest does not reveal exactly the state of affairs which we would naturally

be led to anticipate from a consideration of the history and symptoms described by the patient. It is true that there is relative dullness on percussion at the apex of the right lung; but at certain points we get amphoric resonance, and this is because there are cavities in the lungs here. When the patient opens his mouth, and the percussion is continual, we get a distinct cracked-metal sound. Is this, then, characteristic alone of phthisis? By no means. Only to-day I met with a very instructive case in my office, in which the cracked-metal resonance could be obtained over almost the entire extent of the chest, and yet the patient's lungs were perfectly sound; this being their normal percussion-note in that particular instance.

One diagnostic point about the cracked metal sign in connection with phthisis, however, is that it can be only heard over a circumscribed area. Such is the case here, and in other similar cases.

There can be no doubt that this man has cavities near the apex of each lung, as indicated by amphoric resonance and the cracked-metal detonation on percussion. In addition, I find it quite possible here to make out the existence and the exact localities of some of the cavities, at least, by a simple inspection of the exterior of the chest; and this is especially the case on the left side. At a certain point there, I think you can all notice a depression, of circumscribed area, and that when the patient coughs there is a distinct bulging of the skin over this location. This is certainly an unusually satisfactory demonstration.

Now, the favorable point about this case, and one to which I would particularly call your attention, is that, since these cavities were formed the disease has not apparently progressed in the slightest degree. Since then there has been no fresh tuberculous exudation thrown out, and as a consequence, there is no solidification in the tissue surrounding the cavities. We can, therefore, take this as a sign of encouragement for the patient, and tell him that the disease is no longer progressive in his case, but will now have a retrograde tendency.

Case 4.—Tuberculosis of the Lungs; Formation of Cavity; Arrest of the Disease.

We have here, gentlemen, a patient who is confined to bed for the greater part of the time, and yet I think that I can say, with a considerable degree of confidence, that he is improving.

His name is Charles M. He is a grain dealer by occupation, and a man of great intelligence, and was admitted to the hospital somewhat more than four months ago. He states that one member of his family died of phthisis. He began to have a cough in July, 1872, and it has continued ever since. In November of that year he had hæmoptysis for the first time, and he has suffered from it twice since then. On admission he was troubled principally with dyspnoea and debility, and his cough was accompanied with muco-purulent expectoration. He had lost considerable flesh, but did not suffer from fever, night-sweats, pain or vomiting. A physical exploration of the chest revealed evidences of a cavity, and also of some emphysema. The cough was, to a great extent, paroxysmal in character, and considerable dyspnoea attended it.

Since his admission the patient has certainly held his own, at all events, and, as far as I am able to judge, he has done even more than this. At the present time we find great dullness, on percussion, at the left apex, for the most part, though there is resonance at one point. This, however, is not vesicular, but tympanitic, in character, and is evidently due to the presence of a cavity. We do not always get amphoric resonance from cavities, because they sometimes contain sufficient fluid to modify the sound. Here we get the cracked-metal detonation with great distinctness when percussion is made while the patient's mouth is open. There is cavernous respiration in the upper part of the lung, but normal vesicular breathing below. As has been stated, the man has suffered a good deal from debility, and has been obliged to keep to his bed a great deal since admission; but I do not detect any evidence whatever of new development of the disease in his case. He has, therefore, a good deal in his favor; for, instead of being obliged to contend against fresh exudations of tuberculous matter from time to time, his system has merely to get rid of the products of the disease already deposited in the lung. During the warm weather, which will soon be upon us, I think he will be able to be up and go about more in the open air, and it will undoubtedly have a very beneficial effect upon him, so that I hope that when we come together again in the autumn our friend here, instead of being carried before us on a stretcher, will be fully capable of walking into the amphitheatre him-

self. I cannot impress upon you too strongly the beneficial effect of hope upon our patients; though in phthisis encouragement from the physician is less needed than in most other affections, since it has been almost universally remarked that this disease produces a hopeful effect upon the mind. In general, however, the encouragement of the patient ought to prove a very important feature of our treatment of disease.

COMMUNICATIONS.

A CASE OF SECOND DEVELOPMENT OF PAPILLOMAS IN THE LARYNX SEVEN YEARS AFTER EVULSION OF PRIMARY GROWTHS: WITH SOME CLINICAL REMARKS PERTINENT TO RECURRENCE.

BY J. SOLIS COHEN, M.D.,

Lecturer on Laryngoscopy and Diseases of the Throat and Chest, in Jefferson Medical College; Physician to Jefferson Medical College Hospital, and to the German Hospital of Philadelphia, etc.

In June, 1870, I removed several masses of papilloma, as determined under the microscope, from the larynx of Mrs. J. M. R., now of Allegheny city, Pa. The growths occupied the anterior portions of the superior surface of both vocal cords, and the entire superior surface of the left ventricular band (false vocal cord) clear to the upper level of the aryteno-epiglottic fold. Aphonia was complete; there was some dyspnoea on exertion; hoarseness had commenced nearly two years before, after a cold (catarrhal laryngitis?), and the general health was good. The growths were removed by evulsion with forceps, in a series of operations at short intervals (of a day or two) as is usual; and the raw surfaces were then thoroughly cauterized with deliquesced carbolic acid.

The patient did well; the voice, which became sonorous as soon as the vocal cords were freed from the neoplasms, gradually became as good as ever, and so continued for more than six years; when, after a cold (catarrhal laryngitis again?), hoarseness supervened, and gradually became worse, until a moderate amount of dyspnoea on exertion, and sensations in the throat similar to those experienced a few years before, led the patient to believe that her larynx was again invaded by growths.

She returned to Philadelphia to consult me,

early in November of 1877, and on laryngoscopic inspection, papillomatous growths were seen to occupy the right ventricular band, the posterior portion of the superior, free, and inferior surface of the right vocal cord, and the entire superior surface of the left vocal cord; the left ventricular band being free. Treatment by evulsion with forceps was at once instituted, as before, and the parts were gradually freed from abnormal growths, and then subjected to a number of thorough cauterizations with fused nitrate of silver (crystals molten on a roughened aluminium probe); but the treatment was much more protracted than in the first instance, on account of the position of that part of the neoplasm occupying the inferior surface of the posterior portion of the vocal cord, which I found extremely difficult to subject to effective manipulation.

The voice became sonorous as before, but was still somewhat hoarse when the patient left me, because the cauterization had not yet smoothed the surface of the right vocal cord. Several months afterward, in the latter part of May, 1878, during a meeting of the Medical Society of the State of Pennsylvania, at Pittsburgh, which I was attending, this patient called upon me, and her voice was in good condition.

I have reported but few cases of intra-laryngeal growths of late years, chiefly because there was nothing special to be learned from them. But my personal familiarity with the subject is sufficiently well-known to justify me in drawing some conclusions with regard to the recurrence of intra-laryngeal papillomas and the treatment requisite to prevent recurrence, which I deem particularly appropriate at the present time.

It is usually asserted that recurrence is very frequent. In my own practice recurrence has been quite infrequent, except in cases occurring in tuberculous subjects. I do not know the subsequent histories of the great majority of the cases in which I have removed papillomas from the interior of the larynx, because most of my patients have not been residents of Philadelphia or its vicinity; but as I am indebted for most of these same patients to the kind recommendation of brother practitioners, at home and abroad, it is quite likely that a large proportion of actual recurrences would be reported to me. In several instances, concerning which I have made special inquiry, the reply has

been negative as to any symptom of recurrence; and in several which I have had occasional opportunities of examining during a series of years, I am certain that there has been no recurrence. The few cases of recurrence that have come to my knowledge have, almost without exception, as far as I may trust my memory and the brief records of my case-books, been those in which the evulsion of the growths has not been thorough in the first instance. That incomplete evulsion has occasionally been due to lack of skill in manipulation, I am willing to admit, and I have been in the habit of sending cases which resisted my own efforts to other practitioners accustomed to intra-laryngeal operations, to test their manual dexterity, before abandoning the case to time and physiological resorption; but the most frequent cause of incomplete extirpation has been the premature withdrawal of patients from treatment, satisfied with more or less complete restoration of voice and ease of respiration, and anxious to return to their domestic or their business avocations. Even intelligent people, as all practitioners know, are often exceedingly stupid on medical subjects, and some of them are apt to impute improper motives to manipulations persisted in after freedom of respiration and clearness of voice has been reëstablished. Ignorance, therefore, want of confidence in the practitioner's prognostications, homesickness, and inability to afford the expense of maintenance from home, are, I believe, the main reasons why patients often stop treatment before the growths are thoroughly eradicated. (Some of them, indeed, come to town unprepared and unwilling to remain longer than a day or two.) The recurrence of papillomas, therefore, is, in my opinion, in the main, due to incomplete extirpation, or to inefficient cauterization of the tissues from which they have been torn. There is nothing in their structure threatening recurrence without apparent cause.

In the case herewith reported it will be seen that but a portion of the second batch of papillomas—those occupying the left vocal cord, can really be denominated "recurrent," that is, occupying the site of previous neoplasm. In 1870 growths occupied the anterior surface of the right cord, and the superior surface of the left ventricular band, both localities being normal in 1877; in 1877 growths occupied the posterior surface of the right vocal cord, and the right ventricular band, localities free from

growth in 1870; in 1870 and 1877 growths occupied the left vocal cord, and, what is much to the point, in 1877 the patient reminded me that she left the city in 1870 in opposition to my advice, and that I had expressed want of entire satisfaction with the appearance of one of her vocal cords. Here, then, in this individual case, is strong evidence to prove that there was no recurrence in those localities where evulsion had been thorough, and that there was recurrence in those in which it had been incomplete; and furthermore, that the removal of primary papillomatous growths from one portion of the larynx is no immunity to the development of primary growths in other portions of the larynx. Some reputed cases of recurrence I know to have been new developments. A recurrence of the same cause that produced the initial disturbance that culminates in papilloma, will certainly produce papilloma in similar tissue at a later period. In the case here reported the cause was, in all probability, of the same nature that produced both the papillomas removed in 1870 and those removed in 1877; "cold," as expressed by the patient, *catarrhal laryngitis* as I infer, from her description.

The best method of eradicating papillomas of the larynx is their removal or evulsion with laryngeal forceps, and thorough cauterization of the points of implantation or growth with the laryngeal galvanic-cautery. Soft growths in the upper portion of the larynx can sometimes be dug out or scraped off with the finger nail, as I have been able to do in a few instances. Sometimes, as specially announced by Voltolini, they are soft enough to be brushed off, as it were, with a sponge first passed into the larynx beyond them; sometimes, as we all know, they are soft enough to become detached in spontaneous paroxysms of cough. In the majority of instances, however, evulsion with forceps is requisite. If the growths are located beneath the vocal cords, there is usually so much difficulty in seizing them, that, if the services of a very skillful manipulator are not available, the best practice is to gain more direct access to the growths by exposing the crico-thyroid membrane, to cut this membrane free from the thyroid cartilage, and then to twist, cut, or pull the growths off with forceps, and cauterize the wounded tissue to prevent repullulation; maintaining the orifice in the larynx patent until satisfactory cicatrization has

been completed. If the growths are so situated that they cannot be well reached through the crico-thyroid space, division of the thyroid cartilage becomes requisite, to give more direct access to them. When the growths are above the level of the cords, except in rare instances, where skillful intra-laryngeal manipulation is beyond the reach of the patient, or has failed, and in emergency admitting of no delay, any external operation for their removal is, in my opinion, as unjustifiable, in the main, as incision of the walls of the abdomen and the uterus to remove a child, at term, which is susceptible to skillful delivery with the forceps. The patient would survive in either operation, most likely. Even when located in the ventricles of the larynx, growths can often be successfully extirpated through the mouth, if the ventricular band be first divided, to expose them.

Papillomas of the larynx removed by external operations are by no means less liable to recurrence than others as thoroughly removed through the mouth; and, as a matter of course, neither one operation nor the other can secure immunity from new growth in other portions of the larynx. The sacrifice of vocal cords and other laryngeal structures, for extirpation of benign papillomas of the larynx, recently reported from Great Britain, appears, to my mind, as far as I may judge from the published record, an unnecessary precaution against recurrence, to say the least of it, especially if, as is inferred from the report, no opportunity had been given to test the feasibility of their removal or destruction through the mouth.

1431 Walnut street, Phila., Aug., 1878.

SOME OBSERVATIONS ON OPTICAL DEFECTS, AND THEIR CORRECTION WITH SPECTACLES.

BY DUDLEY S. REYNOLDS, M.D.,
Of Louisville, Ky.,

Professor of Ophthalmology and Otology, in the Hospital College of Medicine, Medical Department Central University, Louisville, Ky.; Senior Surgeon to the Louisville Eye and Ear Infirmary; Member of the Polytechnic Society of Kentucky, etc.

An optical defect is a condition wherein the optical properties or refracting power of the eye is such that rays of light passing through the pupil are not focused in the bacillar layer of the retina.

The general divisions, hypermetropia and my-

opia, refer to conditions directly opposite each other; one being due to insufficient converging power in the crystalline lens, the other being due to an abnormal increase of the distance between the lens and retina.

In hypermetropia of high grade light is not focused at all; while in every form of myopia the light is focused before it reaches the retina; so that in both conditions the visual power is defective, for want of proper adjustment of the refracting media. Hypermetropia may be simple, uniform, irregular in the different meridians, or compounded with myopia; as, for instance, in the eyes of some a certain meridian is found to be hypermetropic, while the opposite meridian is myopic. Analogous complications are frequently found in myopic eyes.

The changes which are brought about by age limit the focusing power, or accommodation, thus diminishing the refraction and giving rise to a condition practically identical with hypermetropia. Hypermetropia less than one-twelfth is likely to be overcome by straining the accommodation power until the subject attains adolescence, except in those cases wherein the defective refraction is greater in one eye than in the other; squint arises from the unequal adjustment, the great strain upon the accommodation in the one eye used produces muscular æthenopia, or spasm of accommodation, and the patient is forced to seek relief. Where the hypermetropia is concealed by the excessive power of accommodation, Mr. Laurence thinks spasm of accommodation exists. This is far from the truth. Spasm of accommodation of the eye is one of those excruciatingly painful states often described as ciliary neuralgia, and cannot be relieved without removing the necessity for that strain which the defective refraction entails.

The almost universal practice of correcting only a part of the defect at a time, gradually increasing the power of the lenses until the error of refraction has been overcome, is not founded in reason, nor is it justified by any man's clinical experience. Donders says, and all the world bow in humble submission to his dictum, that where the error of refraction is different in the two eyes, glasses of equal focus should be ordered, in accordance with the defect in the eye least affected. This is an error; allowing that the accommodation is about equal in both eyes—and it has been observed to differ in the rarest cases only—whatever defect

of refraction may be found should be carefully and entirely corrected, testing always each eye separately; then the accommodative power has but the normal amount of labor to perform; and, no inharmonious work being required, every source of difficulty in the way of defective vision is removed.

Donders says where astigmatism amounts to less than $\frac{1}{10}$ its correction need not be attempted. This error has been a fruitful source of glaucoma; in many instances it has caused posterior staphyloma.

I have been often consulted by persons suffering with asthenopia, and sometimes with spasm of accommodation, who informed me they had been to some famous confrère, who had ordered glasses, and while some benefit had been derived, the weariness, or pain, had returned. Careful testing revealed irregular refraction of low degree, often as low as $\frac{1}{10}$; this being corrected, years of literary labor failed to reproduce the trouble, thus proving the necessity for full correction of the entire deficiency of refracting power.

On the 16th of October, 1876, I was consulted by a lad, thirteen years of age, who had been the rounds of the profession, receiving glasses from each specialist consulted, and, being still unable to read without pain, was obliged to quit school. He had been ordered spherical glasses, $+\frac{1}{30}$ to $+\frac{1}{60}$, all of which improved vision; but the pain would return, and, in a few minutes, reading became impossible. Using a four-grain solution of sulphate of atropia twice every day, in two weeks the pain had entirely ceased; the accommodation being fully paralyzed, I found astigmatism = $+\frac{1}{80}$ in the right eye, and $+\frac{1}{60}$ in the left. The spherical aberration being = $+\frac{1}{8}$ in the right eye, and $+\frac{1}{60}$ in the left. Compound cylindrical lenses adequate to the correction of these seemingly small deficiencies of refraction gave perfect immunity from pain or fatigue, and the lad has gone on with his studies uninterruptedly since he began to use the glasses.

In correcting defects of refraction it is always important to have the accommodating power wholly suspended. Where this is partially done, or not regarded at all, success is impossible.

That the advance of civilization is attended with an increasing number of near-sighted eyes, and that this is largely due to a lack of early correcting congenital defects of refraction, is no

longer to be doubted. The more general diffusion of educational advantages calls for more general use of the eyes for near and accurate vision, and where errors of refraction exist uncorrected, the constant strain of accommodation so augments the tension of the eyes as to produce inflammatory changes in the posterior part of the globe, ending in staphyloma posticum, and its almost necessary accompaniment, myopia.

No mention is made here of that class of defects due to age, because presbyopia depends upon such senile changes in the structure of the lenticular body as tend to reduce the power of accommodation rather than to increase it, consequently, no serious effects are likely to result from neglecting to correct it.

The subjects herein briefly treated are of such great importance to the general practitioner, as well as the specialist, that I feel no apology is due from me for introducing a matter so purely scientific. There is too little attention paid to the early correction of optical defects, and too much aversion, in this country, to the use of spectacles. The sooner these prejudices are overcome, the sooner will there be a decrease in the number of blind people. And it is time the medical profession should cease to encourage the itinerant spectacle vendor, for no one but a practical ophthalmologist is competent to say when we shall wear glasses, what kind we shall wear, and how we shall wear them.

ON THE VOMITING OF PREGNANCY.

BY CHARLES H. HALL, M.D.,
Of Macon, Ga.

I send, for the REPORTER, the following case and remarks:—

June 7th, 1878. Mrs. — is eight weeks advanced in pregnancy; has for two weeks had terrible nausea and vomiting. On two former occasions so extreme has been her danger from this cause that I was compelled to induce abortion, to save her life (this course was only adopted after consultation). On the 5th I thoroughly touched her cervix and os uteri with stick caustic, and at the same time placed her on sulphate of copper, grain one, to water, fluid drachms two, six drops every six hours. Previous to this, for a week, she had retained nothing in her stomach, a teaspoonful of water or brandy and ice being instantly rejected. Her sole nourishment was rectal. This treat-

ment was commenced at two o'clock on the 5th; that night she ate and retained the wing of a small chicken; for breakfast, next day, a leg, and some solid food each other meal. To-day she ate a piece of steak and bread. Although thus eating and retaining what she eats, she says her nausea is constant and not at all improved. Her bowels are regular, and her food evidently agrees with her, so I am content to wait.

June 17th. Three days after my last note in regard to this case a hemorrhage occurred, and I feared abortion; under the influence of fluid extract of black haw the hemorrhage ceased, and no abortion occurred. Simultaneous with the hemorrhage all nausea disappeared; that stopped, the nausea returned, with some vomiting. After Copland, I dilated, with my finger, the os, and gave half a drop of tincture of nux vomica every two hours. My patient is now taking her three meals a day, and I have every hope that her greatest trouble is over.

June 22d. Patient slightly nauseated, she says, all the time; yet she is cheerful, and eating and sleeping regularly.

June 26th. On the evening of the 24th she became suddenly intensely nauseated, and commenced retching, not being able to retain anything on her stomach. Yesterday, at four o'clock p.m., I again applied caustic. She ate breakfast this morning, and again dinner, yet not admitting that she was any better. (This seems to be her peculiarity.)

June 27th. Some nausea, but very bright, and good appetite.

June 29th. Stomach again rejecting everything, nausea excessive, etc. Applied electricity, one pole over epigastrium and the other over spine; no apparent relief; again prescribed nux vomica.

June 30th. Patient no better in any respect; very weak, intense headache. With a saturated solution of nitrate painted her os and cervix.

July 1st. No better, nausea extreme, cannot retain anything. Electricity over spine and abdomen.

July 2d. Found her very little better; had been able to retain a little milk. Reapplied electricity, and ordered fifteen grains of chloral per rectum every six hours.

July 6th. Since the morning of the 3d she has been retaining everything; has still nausea. Continued chloral.

July 8th. Doing well, but has some vomiting and very much nausea.

July 17th. She is doing well; has more or less nausea, though still in bed and unable to sit up, even in bed; but as she retains her food and is daily gaining strength, I consider her as no longer needing treatment.

There necessarily seems to be no settled principle for treating this very common affection; we must try, in succession, different remedies; and although we know many that have relieved, yet, in a given case it seems impossible to prescribe the right one by any indication presented. Ipecac, nux vomica, oxalate of cerium, etc., will each frequently relieve, yet I know no settled indications for one or the other.

In 1877 I saw a lady in consultation, whose suffering was so extreme that an abortion was deemed necessary by her medical attendant, he having tried a number of remedies. In her case examination revealed a slight version. She was placed in the genu-pectoral position, after Campbell's method, the version corrected, a ring pessary applied, and drop doses of wine of ipecac was ordered every hour; she was speedily free from nausea. I had recently a severe case, and as I was not allowed to examine, I empirically gave one remedy after the other; when the turn of nux vomica came, one-half drop every hour, the patient was soon well. Was the cure *post hoc* or *propter hoc*? This lady, that the nux vomica seemed to cure, did not appear to have lost much flesh, yet she said, and her friends coincided, that she ate very little, and apparently vomited up that little, and this for two weeks before I saw her, and certainly for two weeks after my visits began; there was, of course, some weakness. Hers was simply a sympathetic disturbance of the stomach, not one of those terrible cases (as my present patient) where it seems a horrible disease, and you are tempted to look for inflammation of the stomach to explain the apparently grave symptoms that certainly threaten life. I have witnessed one death from this vomiting.

My experience has taught me not to rely on remedies alone, but in conjunction with them, taking Graily Hewitt's advice, I correct any uterine misplacement that may exist, and, if necessary, apply a pessary. Since I have become acquainted with Campbell's genu-pectoral position and his method of self-replacement, I having once corrected the misplacement, instruct the patient how she may be daily her

own gynecologist. I rarely find a pessary necessary after a few days of this practice, and the patients experience a great deal of comfort from it. I have for more than twenty years been in the habit of applying either nitrate of silver or tinct. of iodine freely over the os and cervix uteri, either seeming frequently to break the link in the chain of reflex irritation that affects the stomach. I was very much surprised at seeing it presented, by Dr. Jones, of Chicago, through Dr. Marion Sims, in the *London Lancet*, as a new treatment. In May, 1855, I settled in Milledgeville, Ga.; my best friend and adviser was the late Dr. Saml. G. White, of that town, and it was his commonest prescription, saying, "attack the seat of the disease." He did not claim it as original, and I supposed he had read it in the journals. I afterward saw some similar suggestion in Bennett's work. I practiced it as early as 1857, after Dr. White's plan, using either the stick or the saturated solution as was most convenient. Thinking well, as expressed above, after long acquaintance with and frequent use of this procedure—I say frequent use because I have advised and prescribed it where the nausea was an annoyance (not a disease) and the patient desired freedom from it if possible—I cannot say that it acts "like a dose of quinine in ague." It failed signally in the lady's case above narrated, two years ago, and after its use, to save her life, we were compelled to induce abortion.

I send you this case, occurring just as Dr. Jones' article in the *Lancet* is being republished. It is a fair test case of this method of treatment. The lady having suffered so extremely in former pregnancies, I think we may legitimately place this method of treatment as all else that has been proposed in vomiting in pregnancy, as a means to be tried, but as presenting no more certain results than other therapeutical measures. It seemed in this case, on several occasions, to give great relief, yet the relief was very transitory, and finally it lost all controlling power. At last, having used the electricity and chloral contemporaneously, it is impossible to decide which was the most potent factor in relieving her.

Animal Vaccination in Prussia,

Dr. Pissin, of Berlin, publishes the statistics of his use of bovine virus. Of first vaccinations he succeeded in 90 per cent. of the cases; in revaccinations, in 42 per cent. In a number of the cases he used the virus suspended in glycerine.

HOSPITAL REPORTS.

JEFFERSON MEDICAL COLLEGE HOSPITAL.

CASES FROM THE CLINIC OF PROF. GROSS.

REPORTED BY FRANK WOODBURY, M.D.

Dislocation of Tibia Forward on the Femur.

Victor D., 20 years of age, was brought from Ashland, Schuylkill County, by Dr. Bowen, with lameness of the left leg, produced by an injury seven weeks before. The case had only been under the care of Dr. Bowen for one week, who gave the following history: While ploughing, the horse ran away, throwing patient violently to the ground, where he lay unconscious for several hours. No statement could be obtained of the condition of the parts immediately after the accident, but there was great contusion of the left knee-joint, and a fracture having been suspected, the patient had been kept on his back, with extension upon the limb.

When brought into the clinic room, it was pronounced a luxation of the knee, the head of the tibia riding forward in front of the condyles of the femur—a rare form of dislocation. Of the four displacements of the knee joint, forward, backward, or to either side, the antero-posterior dislocations were pronounced the more frequent. All these dislocations, however, require direct violence, of powerful degree, in order to displace the bones, and are generally attended with more or less rupture of the ligaments and muscles, and sometimes of the popliteal vessels. Prof. Gross could, at the time, only recall one other case, from his long experience, where this condition existed. The former being a recent accident, he was enabled to reduce the dislocation by making extension and counter extension, placing his arm as a point of support under the condyles of the femur, while forcibly flexing the knee.

In the present subject, the accident having occurred nearly two months previously, the prospect of relief was not favorable. Upon examining the joint, it was seen to be larger than the corresponding knee, being particularly prominent in front and in the ham. The patella was movable, and lay above and to the outer side of the greatest prominence in front, which was thought to be the head of the tibia. Posteriorly the condyles and the intercondyloid notch of the femur were so clearly defined as not to admit of mistake. As the patient lay upon his back, the entire anterior outline of the left leg was elevated at least two inches above that of the right. The foot was rotated somewhat inward, so that the line of the foot was rather nearer to the middle line than normal, and the limb was shortened from one and a half to one and three-quarter inches. There was no marked oedema of the knee or of the ankle, and the skin

was discolored only at the back of the joint, where it was pressed upon by the condyles of the femur. The leg was very nearly in a straight line with the thigh, as the patient lay in bed.

In attempting to reduce a dislocation of this kind, it will be necessary to give chloroform, proceeding with caution in our manipulations, for fear of injury to the popliteal vessels. After having been on the stretch for some time, their walls may have undergone some inflammatory or degenerative changes, so as to render them unusually brittle. It would require but little effort to tear the vein across and seriously complicate the case; or the artery might rupture, or its tunics partially yield, occasioning a copious subcutaneous hemorrhage or an aneurismal tumor; both of these accidents have been produced in such cases.

We find that the limb admits of some flexion at the knee, but that it is rotated on its axis more readily and to a greater extent than normally, and also admits of lateral motion more than in the natural state. In making attempts at replacement, the muscular system being thoroughly relaxed by chloroform, extension and counter-extension are sustained by assistants, while the surgeon firmly grasps the leg below the knee, and flexes the joint on his left forearm placed in the ham. The parts yielded considerably, the leg forming almost a right angle with the thigh, but it was impossible to accomplish reduction. Caution was advised against too great force, on account of the danger of breaking the thigh bone. The compound pulley was resorted to, gradually extending the limb so as to fatigue the muscles, but no better result was obtained; the objection being that manipulation and flexion interfered with the fixed extension. [At a subsequent clinic excision of the head of the tibia was performed, and the man obtained a useful limb.]

Lymphadenoma.

Ulyses B., four years of age. Notice particularly the child's pallid complexion, and in connection with it this tumor on the right side of the neck, which was noticed immediately after birth. The growth is very large, and is not tender; manipulation does not cause any signs of discomfort on the part of the little patient. The skin is movable over the swelling, and appears normal.

The child's general health gives the mother more uneasiness than the swelling. His appetite is capricious; he is losing flesh; has fever every afternoon; the symptoms becoming more severe, and the child failing rapidly during the last seven weeks.

Anæmia is a prominent feature in this case. From the hue of the skin and pearly conjunctiva, there is a deficiency of the red blood globules, and, doubtless, of fibrin. The relative preponderance of white blood globules, as a distinct pathological condition, was described simultaneously by Virchow, and by Bennett, of Edinburgh, and called leucocythemia by one, leucæmia by the other.

Lymphadenoma is liable to attack the glands of the neck, but may occur elsewhere, as in the lymphatics of the groin, mesentery or trachea.

In the course of the disease the pulmonary tissue is liable to be invaded by the growth of such tumors, presenting a structure resembling the mammary gland. The spleen is sometimes attacked, but rarely after the twenty-first year. How this morbid process is originally introduced is not definitely known. It may have been an inherited tendency, aggravated by the influence of cold, deranged digestion, or some vitiated secretion; but, however this may be, it is certainly connected with the disorder of the blood, though exactly in what manner no one has yet ascertained. An increase of the white blood cells takes place, similar to that occurring in inflammation. The red cells are diminished by some unknown process. Placing a hand on the surface of the tumor, we find that the skin feels hot, but elsewhere it is normal. This proves that morbid action is now progressing in the growth, that there is undue vascular and nerve activity, the greater amount of circulation causing heat and rapid development, which, unchecked, may continue until the tumor attains enormous size.

Referring to treatment, no satisfactory course has been devised; the case must be treated solely on general principles. The anæmia indicates some remedy to improve the condition of the blood, such as chalybeate tonics with quinine, the latter being needed both as a febrifuge and tonic. He shall take—

| | | |
|----|------------------------|--------|
| R. | Quinæ sulph., | gr.j |
| | Tinct. ferri chloridi, | gtt.v |
| | Syr. aurantii cort., | 3j. M. |

Sig.—Ter die.

The improvement of the blood will be insured by a nutritious diet of milk, cream, eggs in abundance, poached, soft-boiled or beaten up with brandy or whisky, at least two being given in the twenty-four hours; beef essence, barley-bread and butter, in short, concentrated nourishment that admits of easy digestion. A teaspoonful of brandy may be given three times a day. As his tongue is slightly coated he shall take, for its alterative and antacid effects—

| | | |
|----|----------------|--------------|
| R. | Pil. hydrarg., | grs.ij |
| | Sodii bicarb., | grs.viij. M. |
| | Ft. chart. | |

Sig.—To be taken every fourth morning.

The belly is tumid, due to flatulence and enlargement of mesenteric glands.

To the surface of the tumor an evaporating lotion shall be applied, acting on the principle of retarding growth by the abstraction of heat. A solution of acetate of lead (an ounce to the pint) shall be used, a piece of flannel being doubled, covered with oiled silk and wet four times in the twenty-four hours. The prognosis is generally as unfavorable as possible, and in this case we can scarcely hope for more than palliation.

EDITORIAL DEPARTMENT.

PERISCOPE.

Medical Uses of Carbolic Acid.

Dr. Peter Eade has an excellent article in the *Lancet*, from which we extract, as follows:—

The diseases in which I have found the carbolic acid especially useful are—1. All that class of local, festering, pustulating diseases of the skin which are at once so common and so difficult to cure. They include all kinds of pustules, boils, and carbuncle; sycosis, pustular acne, and festering ringworm. 2. Such strumous sores (especially of the neck) as come under the care of the physician. 3. Excoriations of the os and canal of the cervix uteri. 4. Phthisis in its second and third stages, and cases of chronic bronchitis accompanied with more or less purulent expectoration.

I have said, that in order to be effective, the carbolic acid must be brought into contact with the part to be acted on, and I doubt not that in many cases where it has been found ineffective the failure has been due to a neglect to ensure this contact. In the pustulating and suppurating diseases of the skin I have mentioned it is never sufficient to apply the solution of the acid, of whatever strength, upon or to the outside of the skin. It must always be introduced into the interior of the sore or pustule itself, and so as to come sufficiently in contact with every part of the diseased surface. Of its efficacy thus applied I have now had a very considerable experience, and so certain am I of its curative powers in these cases, that I state, with the utmost confidence, that all cases of boils and carbuncles in their earlier stages can be absolutely aborted and cured, while even in later stages their further increase can be almost surely prevented. For this purpose a very strong glycerine solution should be employed, and it is best conveyed into the interior of the pustule, boil, or suppurating spot, by a new quill pen dipped into the solution, and introduced by a rotatory motion through its apex, where a sufficient aperture will generally be found. In carbuncles, which are necessarily larger, and have often several openings, several such introductions may be necessary, or, at a later period, threads of lint soaked in the fluid may be passed with a probe well into all the sieve-like openings. Occasionally, as when the mass is large and solid, a watery solution of the acid may be injected with a hypodermic syringe into various parts of the hardened growth. The same plan of treatment is often quite effective in cases of sycosis, pustular acne, and festering ringworm. And it is doubtless so because it destroys germs which, living in the involutions of the skin, are the essential cause of these

various diseases. In the case of acne, and of boils and carbuncles, the essential dependence of these diseases upon vegetable germs has scarcely been demonstrated, but their mode of origin and growth, their whole life-history, and their curability by such local means alone, go far to prove that they, like other skin diseases, are due to the development in the cutaneous textures or glands of parasitic growth. As, however, I have already published in the medical journals several papers on this subject, I will not longer dwell upon it now. Not long ago it was stated that the development of the vaccine vesicle could be prevented by the application of carbolic acid to the vaccinated sore. If this is so, it would seem highly probable that the same kind of destructive influence would be exerted upon the small-pox eruption, if the acid were applied to the pustules before or during the process of their maturation. The process of introducing a little of the strong acid solution into the apex of each pimple would be tedious and disagreeable, but if effective, it might not only save much disfigurement, but possibly even life itself. Darkening of the patient's room, blackening of the face, covering up the pimples with wet clay (as practiced by some savage tribes)—all expedients for preventing the free development of the local disease—appear to diminish its virulence somewhat, and possibly this more direct interference with the special virus might do much more to mitigate its severity. Various applications to the general surface have been tried and failed more or less completely, and Velpeau has advised the cauterization of the individual pimples with solid nitrate of silver; but I am not aware that carbolic acid has ever been fairly thus tried, and I recommend it to your consideration when cases of this dire disease come under your notice.

2. The healing of strumous sores may be frequently much expedited by the bringing into contact with their interior or open surface a sufficiently strong solution of carbolic acid; and old stationary sores will often at once begin to heal when acid is so applied. So, too, when they are first opened, their immediate healing may sometimes be brought about by injecting into them a solution of the acid, and keeping the opening closed against the admission of air. This method of treatment, on a larger scale, has been advocated by Mr. Callender in the case of spinal abscesses, and some very successful results have been recorded.

3. In excoriation, or so-called ulceration of the neck of the uterus, the strong glycerine solution is a most valuable application, and in my hands has been far more efficacious than nitrate of silver or other usual caustics. In these cases the denudation of epithelium is, commonly, not only of the vaginal surface of

the os, but it extends up along the canal of the cervix, and often (as Dr. Playfair has shown) into the cavity of the uterus itself. I have found no ill effect from applying the strong glycerine solution freely, with a camel's-hair brush, within the cavity of the cervix; and, indeed, it is not only well and painlessly borne, but is often very effective in promoting the healing of the "ulcerated" surface. I have thought it possible that its undoubted efficacy may be partly due to a power of destroying any bacteria or other germs living in the uterine mucus, and by their presence irritating the secreting surface, and so preventing the formation of healthy covering epithelium.

4. In cases of phthisis which have passed their earliest stage, and in which the sputum is of a muco-purulent character, you have almost daily opportunities of witnessing the efficacy of carbolic acid inhalations. In three patients now in the hospital the cough has been greatly lessened by its use, while at the same time the secretion of purulent mucus has been greatly diminished in quantity. As you have seen, we employ it in the simplest fashion. We give the patient a solution of the acid in water containing ten grains to the tablespoonful. We tell him to add this to half a pint of hot (not boiling) water in a narrow-mouthed jug surrounded by a towel or handkerchief, and then to inhale this for about ten minutes; and we order the inhalation to be repeated three, four, or five times in the twenty-four hours, according to the necessities of the case. The inhalation can, of course, be made through any ordinary inhaler, or it can be used with the acid in more concentrated solution, or in the form of spray; but I have found the above method not only simple and always available, but perfectly efficacious.

Cleanliness in Surgery.

Mr. G. W. Callender, of St. Bartholomew's Hospital, London, believes that the main if not the sole merit of the "antiseptic" treatment is its cleanliness. In a late number of the *British Medical Journal*, he writes:—

In illustration, the case of a patient aged 16 may be referred to. For the treatment of a severe case of genu valgum, I opened the knee-joint, and with a saw separated the internal condyle of the femur from the shaft of the bone. The condyle being displaced upward, the limb was easily brought into the straight position, and in that position was secured by a long splint (Dr. Ogston's operation). The wound, which admitted at one and the same time the long knife used for penetrating and dividing the soft parts and a stout saw, had a depth of about three inches, and where the skin was divided, a length of about one inch. No carbolic or other spray was used at the time of the operation, or at any time subsequently. The wound was covered with a doubly-folded piece of lint soaked in carbolized oil (1 in 12); over this was placed a large piece of lint, likewise soaked in oil; and over all a yet larger surface

was covered with some ordinary gutta-percha tissue. The dressings were examined daily, the gutta-percha tissue being lifted and the outer layer of lint being changed, the gutta-percha being then replaced. The inner layer of lint was left undisturbed on the wound for three or four days, being each day refreshed with carbolized oil (poured upon it or painted over it with a camel-hair brush). Whenever this layer of lint was changed, the wound was freely exposed to the air. The patient got well without any constitutional disturbance, and the parts healed in the ordinary course. Treated in a similar manner, there are at this time under observation in one of my wards a severe compound fracture of the femur into the knee-joint, and two cases of compound fracture of the leg; in one of the latter, it was not necessary to disturb the inner layer of lint for nine days after its first application.

Of course, these are but casual illustrations, from many similar cases, to show how a very simple plan suffices to ensure that condition of cleanliness which is essential to the sure and rapid healing of severe wounds, or wounds inflicted upon parts which it was formerly considered hazardous to involve in operations. With this cleanliness must go "rest," and with this will be ensured "ease," and when deep wounds, or wounds the surfaces of which are not easily and closely adapted, are concerned, thorough drainage is of prime importance.

The Use of the Cold Bath in Febrile Diseases.

Dr. A. T. H. Waters, of Liverpool, gives the following case in the *British Medical Journal*, as illustrating the cold bath treatment:—

I was summoned on May 15th, 1876, to see a patient who was under the care of Dr. Johnstone, of Upholland. The patient was a married lady, twenty-six years of age, of strumous aspect, suffering from an attack (the first) of acute rheumatism, with pericarditis. Her attack had commenced on May 8th, and she was first seen by Dr. Johnstone on the 10th, when the temperature was 104°. During the four following days the temperature, when taken, ranged between 104° and 105°. I saw the patient at 5 p. m. on May 15th, about the eighth day. The case was one of severe rheumatic fever, and the physical signs of pericarditis were well marked. The patient was restless, but free from delirium. The pulse was 120, and the temperature 104.2°. The urine was very acid. The treatment which had been adopted by Dr. Johnstone was the administration of bicarbonate of potash, with bark and opium, and four ounces of brandy daily. I recommended that the treatment should be continued; the dose of potash, however, to be increased, and that of opium diminished. I further advised that, should the temperature rise to 106°, the patient should be put into a bath at 95°, to be cooled down to 75° or 70°. On the following day, at 1 p. m., Dr. Johnstone found the temperature 106.2°, accompanied with "fu-

rious delirium." Dr. Johnstone says: "I had her put into a bath (tepid), which was quickly cooled down to perfectly cold. (I cannot give you the temperature, but the water was cold from the pump.)" The patient was in the bath half an hour. The delirium sensibly decreased during this time. She slept a little the night after the bath, and on the following day she slept profoundly for two or three hours, and after this there was no delirium. At 10.30 P. M. of the 16th—viz., between eight and nine hours after the bath—the temperature was 102.6°. On the 17th, at 9 A. M., it was 103°; at 3.30 P. M., 102.8°; and at 10 P. M., 102.8°. Dr. Johnstone says: "Beyond this, I have no further record. I can only say that her progress toward recovery was constant."

Tracheal Injections in Croup.

The *Doctor* says that Dr. Palvadean, of Monaco, has injected perchloride of iron into the trachea through the parietes, by means of an ordinary subcutaneous syringe. He thinks in this way it is easy to bring the medicine to the diseased mucous membrane, and reports some cases in which recovery followed.

Dr. Régi, of Toulouse, writes in the *Courier Médical* in favor of this method. He has injected from 6 to 15 drops of a solution of perchloride in an equal weight of water. He gave the same remedy by the mouth, but attributes much of the effect to the injections.

Neither of these writers think there is much danger in thus penetrating the trachea. Dr. Régi says if a small vessel were wounded hemorrhage would be averted by the iron. He found, too, that swelling followed and interfered with deglutition, but was relieved by belladonna ointment. Of course, in ascending croup the remedy would be useless, and we do not think it is likely to find favor in other cases in this country.

Salicylate of Soda in Rheumatic Fever.

Dr. James Martin writes to the *Medical Press and Circular*—

In the *Medical Press*, August 1st, 1877, I reported two cases of rheumatic fever cured rapidly by salicylate of soda. I have since then treated four other cases, with exactly similar results. It would be useless to give their details individually; I will, therefore, state the points which struck me as worthy of notice. Each case had swollen, painful wrists, elbows, and ankles; in one only the knees were swollen. The temperature ranged, on my first visits, from 102° to 104°. They were all sharp, acute cases, with severe pain; all under six days from the time of first seizure. The medicine was given in half-drachm doses every four hours; all were literally cured on the third day after beginning its use. One, however, returning to his work on the sixth day, in very bad weather, got a relapse, for which the salicylate did no good; but he quickly recovered under the use

of the perchloride of iron with blistering fluid applied over the painful joints. This was the only patient whose heart became affected, but it was not seriously so.

In every case the medicine produced a profuse diaphoresis, during which I observed that the skin retained its tone, felt firm, though moist in a peculiar manner, as I also noticed in a case of different disease, which follows this. I have tried the salicylate in less acute cases several times, but did not obtain the slightest benefit. This fact was also noted and stated to me by a most respectable, intelligent practitioner in the midland counties, as being the result of his experience before I had told him of mine.

The Pathological Traces of Pulmonary Hemorrhage.

Dr. Reginald Thompson read a paper on this topic before the Royal Medical and Chirurgical Society of London. He said that the traces of pulmonary hemorrhage most frequently found in the lungs after death are small rounded or ovoid masses, whose size ranges from a pin's head to a filbert, and which vary in color, according to their age, from a blood-red to an ivory-white; they are smooth, firm and tough in texture, and are found to consist of blood corpuscles and fibrin packed closely in the alveoli. Their position is peculiar, and the special localities which they haunt show that the force of inspiration is the active power by which the blood is impacted in the alveoli. Hence these traces indicate hemorrhage transferred from some other distant part in the lungs. Their future condition appears to depend upon the absence or presence of other pulmonary disease. There are other traces which point to extravasation of blood *in situ*. In these cases, which are more rarely met with, there is considerable pigmentation of the neighboring tissue, and occasionally laceration. In either case, whether the blood be transferred from a distance or deposited *in situ*, softening and elimination may occur, so that a cavity may be the result; but it is very difficult to form an opinion with reference to the relation of these hemorrhagic deposits and tubercle.

The Temperature in Pleurisy.

According to Dr. Peter, of Paris, the temperature of the side affected with pleurisy is always greater than that of the sound side; and this increase of temperature continues in proportion to the effusion, and may even reach 2.5 and 3 degrees C. above the normal standard. It then falls when the secretion stops; but nearly always it continues by 0.5 to 1.5 of a degree in excess of the temperature of the healthy side. This hyperthermy persists, even after the reabsorption of the effused liquid, and it is this persistence that explains the possibility of relapses. In cases of dry pleurisy, or pleurisy without effusion, the local hyperthermy is less elevated than in pleurisy with effusion,

and the return to the normal temperature takes place more rapidly. The above applies to pleurisy left intact, or unrelieved by thoracentesis; but when the operation is performed the local hyperthermy is the consequence of hyperæmia *a vacuo*, as takes place in ascites. In cases of pleurisy, this hyperæmia, which is altogether local, is necessarily added to the previously existing phlegmatic hyperæmia, against which the operation was without curative action. Thus we have two hyperæmias instead of one, with all their consequences—such as augmentation of tension in the blood-vessels of the inflamed pleura, purulent transformation of the effused liquid, syncope, pulmonary congestion, consecutive albuminous expectoration, pain, dyspnoea, sometimes amounting to suffocation. The conclusions arrived at by Dr. Peter rather tend to show that thoracentesis is not, after all, so inoffensive an operation as it is made out to be by some enthusiasts; and it behooves every practitioner to pause and consider well before he would thrust an instrument into a patient's chest.

The Value of Quinine Solution in Vesical Irritation

Dr. J. K. Thornton writes to the *Lancet*—

Some few months back I heard, through Mr. Spencer Wells, of the value which Mr. Nunn attached to the local use of quinine in chronic irritation of the bladder. I had in hospital at the time two patients whose convalescence after ovariectomy had been much retarded by this condition, which is so apt to arise from the nurse not being sufficiently careful as to the condition of her catheter. Both the cases had defied frequent washings out of the bladder with solutions of carbolic acid, etc., and both patients were feverish, passing much mucus in ammoniacal and offensive urine, with constant desire and severe dysuria.

I treated both as follows: The water was drawn off with a No. 12 gum-elastic catheter, and the bladder thoroughly washed out with tepid carbolic lotion, 1 to 100, four ounces being introduced and then withdrawn, the process being repeated till a pint had been used for each. (This had been done each day for several days, two ounces of the solution being left in the bladder without the slightest relief or improvement.) Four ounces of water were then introduced and withdrawn. Not knowing the exact strength of the solution used by Mr. Nunn, I had one made with two grains of quinine to the ounce, and a few drops of dilute sulphuric acid to dissolve it. Three ounces of this solution were introduced and allowed to remain in a few seconds; then two ounces were withdrawn, the other ounce being left in the bladder, the patient having instructions not to pass water for an hour. The first patient had some smarting and forcing, which lasted for twenty minutes; the second no inconvenience whatever. In twenty-four hours I noted, as to them both: "Urine acid, much improved in general appearance; no mucus, and odor

normal." Two days later I noticed in their case-books, "No more trouble with urine since the acid quinine injection; urine normal."

Treatment of Hydatid Cysts.

At a branch meeting of the British Medical Association, Dr. Eddison made some remarks on the treatment of hydatid cysts, and referred to the detailed reports of three selected cases from his own practice in the Leeds Infirmary, illustrating different forms of the disease. His opinions as to treatment, which, he believed, agreed generally with those of most persons having much experience of the disease in question, were as follows. Cysts should be emptied as soon as they are discovered. The fluid should be withdrawn by an aspirator, using a very moderate degree of exhaustion, and a very fine needle should be used. There is no need to attempt to cause adhesions to the external coverings, the abdominal wall or the costal pleura, for example. If care be used, the suction of the aspirator does not cause pain; but pain may often be produced by allowing the point of the needle to move about unnecessarily. The cyst should be as nearly emptied as possible; for the less fluid that the punctured cyst contains, the less chance is there of the outflow of such fluid through the puncture. Nothing whatever should be injected into the cysts. As soon as pus is evidently present, an opening should at once be made, and the suppurating cyst be treated as an ordinary abscess, bearing in mind that the cyst-wall and secondary cysts should, if possible, be removed.

On Retention of the Urine in the Female.

Dr. J. H. Croom ends an article in the *Edinburgh Medical Journal*, on this subject, as follows:—

It would thus appear that the causes leading to retention of urine in the female may be thus conveniently grouped:—

1. Injuries or contusions during labor, acting directly or by subsequent inflammations.
2. Pressure of displacements or tumors acting mechanically on urethra or neck of bladder.
3. Injuries or growths acting reflexly.
4. Diseases of nervous system.
5. Direct obstruction within the tube of the urethra, as from stricture or foreign bodies, such as a calculus.

In drawing this paper to a conclusion there are one or two points which seem worthy of note.

1. In all cases of retention of urine a vaginal examination is necessary.
2. A gum-elastic male catheter of medium size, without the stilette, is the best form of instrument to employ.
3. In retention from displacement it is important to remember the altered position of the urethra. In retroversion of the gravid uterus the vagina is drawn upward and forward, the meatus is drawn upward, and the direction of

the upper part of the canal is backward and downward.

4. When any difficulty exists in accounting for the retention a visual examination should be insisted on.

5. It is a safe rule, before giving a definite verdict on any pelvi-abdominal tumor, to empty the bladder.

New Operation for Removal of the Penis.

Mr. Stocks showed a man at the Manchester Medical Society, whose penis he had removed in a novel manner. The urethra was quite patent at the orifice, and he could pass urine with perfect ease. The operation was performed thus: A narrow-bladed knife was passed between the corpora cavernosa, and the corpus spongiosum, about an inch behind the diseased part, and the former bodies were divided directly upward. The knife was then placed in the bottom of the wound and carried directly forward for about one-third of an inch, and then diagonally downward and forward, forming an inferior flap. The urethra in this part was then freed from the corpus spongiosum, and loosened slightly from its attachments. The skin-flap was turned upward, and a small slit or button-hole made in it, through which the loosened urethra was drawn by forceps and held until the skin-flap was adjusted and secured. The cut end of the urethra was then stitched to the edges of the button hole. There was a redundancy of skin, but it formed an admirable artificial foreskin, to protect the tender orifice of the urethra from injury, and formed no impediment to micturition when drawn back in the ordinary manner.

Treatment of Typhoid Fever.

Dr. J. R. Groover, of Mica, Pickens Co., Ga., writes to the *Atlanta Medical and Surgical Journal*—

I propose briefly to give a plan for treating typhoid fever that has proved very successful in my hands, having used it in a great many cases during the past three years:—

Diluted phos. acid, 20 gts. every four hours through the day, alternated with a powder composed of ipecac. camphor and prepared chalk, powder being changed as indications may require. To allay nervous irritation and procure rest, bromide potassium every three hours through the night.

If the patient has more than three operations on the bowels in twenty-four hours, I usually prescribe tannic acid and opium, to be taken every time the bowels operate, until the diarrhoea is checked or the patient is thoroughly under the influence of the opium.

These remedies, with sponging the body and cold cloths to the head when the fever is high, and corn whisky through the night, if it is of the lower grade, with the necessary nourishment four times a day and once at night, will cure nearly every case of uncomplicated typhoid fever.

REVIEWS AND BOOK NOTICES.

BOOK NOTICES.

Vorträge aus dem Gesamtgebiete der Augen-Heilkunde für Studierende und Ärzte. Von Dr. Ludwig Mauthner, k.k., Universitäts Professor in Wien. Erstes heft; *Die Sympathischen Augenleiden*. Erste Abtheilung; etiologie, pathologie. 58 pages. Price \$1.40. B. Westermann & Co., 524 Broadway, New York.

Dr. Mauthner, Professor of Ophthalmology in the Imperial University of Vienna, has commenced the publication of a serial work on Diseases of the Eye, the first part of the first number of which has just appeared under the title given above.

The object of the author, as stated in the announcement of the publisher (Befgmann, of Wiesbaden, 1878), is a double one: to make each article so exhaustive as to satisfy the demands of the specialist, and at the same time to enable the general practitioner to find in the work a text book so complete that, without any previous study of ophthalmology, he may acquire, by its means, a well-grounded knowledge of the subject in all its departments.

The first part (58 pages) of the first number, which treats of the etiology, pathology and diagnosis of "sympathetic ophthalmia," seems to us to justify, in every respect, the claim that is made for the twofold character of the work.

The author's large experience and great erudition are eminently conspicuous in the preparation of this first article, and the very latest observations from all sources bearing upon the subject are carefully collated and compared. The various forms "sympathetic ophthalmia" may assume are described with a completeness and attention to detail which is to be found in no other work with which we are acquainted.

From four to six numbers are promised annually. The second part of the first number will complete the subject of "Sympathetic Ophthalmia." The second number will be devoted to "Brain and Eye," in their relation to each other, and the third entirely to "Glaucoma."

THE
Medical and Surgical Reporter.

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

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**PLANS OF RESTRAINING GROUNDLESS SUITS
FOR MALPRACTICE.**

There are few experiences in the life of a physician more annoying than a suit for malpractice, no matter whether he feels himself wholly innocent of the charge or not. He is well aware that being innocent is one thing, and persuading twelve men ignorant of the first lines of medicine and surgery that he is, is another thing. Then, allowing other matters to be equal, his opponent may have secured a specious and cunning lawyer, who will so befog the whole case that the jury are as liable to find for as against the party in the wrong.

Hence, it is of importance to the whole profession, that in every State it should frame and have passed by the Legislature such Acts as will protect the physician against such uncalled-for attacks. This seems to be best met by giving the physician the right to recover damages in case the plaintiff fails to substanti-

ate his allegation. At a meeting of the State Medical Society of Maine, last year, the President, Dr. EUGENE F. SANGER, of Bangor, suggested remedies of this character:—

1st. Petition the Legislature to enact a law compelling patients suing for malpractice to give bonds to pay all taxable costs in case of defeat. As it now is the poor patient has everything to gain and nothing to lose by a prosecution in the hands of an unscrupulous pettifogger, while the surgeon has everything to lose and nothing to gain.

2d. If this fails, issue a blank, and put it into the hands of every doctor, to be signed by the patient in every instance, agreeing to hold the surgeon harmless in the legitimate pursuit of his profession.

We have been recently asked by a correspondent whether any State has actually enacted laws protecting the physician against causeless suits for malpractice. So far as we know, none of them has; and if our knowledge is at fault we should like to be corrected, and have sent us, for publication, a copy of the Act.

In many instances threats of a suit are used to extort money of physicians or to persuade them to cut down or wholly yield their bills. This many will do, though knowing they could successfully defend their course; because, at any rate, they would lose their time in attending court, have to pay heavy lawyers' bills and witness fees, suffer much worry and anxiety, as well as certainly expose their reputations to the strictures of professional rivals and personal enemies. All this could and ought to be prevented by proper and united action by the profession.

It is notorious, in every community, that there are pettifoggers—common barrators—ready to stir up litigation against any well-to-do professional man, acting on what Sam Weller called the “very generous line of takin’ the case on spec, and chargin’ nothin’ for costs unless they got ’em out of the defendant.” The surgeon is

often called to a case where, with the utmost care and complete success, he can expect neither gratitude nor much of a fee; but where, in the event of even apparent failure, he will run a large chance of legal annoyance. It is time that some check was put to these opportunities of mulcting innocent and worthy practitioners.

NOTES AND COMMENTS.

Scrofulous Patients.

In a recent address, Dr. T. Clifford Allbutt remarked that he had taught, for fifteen years, that a scrofulous patient was simply a bad healer, one in whom light lesions were not easily thrown off and forgotten. The so-called scrofulous neck, long regarded as the expression of a special systemic vice, probably always took its rise as a bubo, from some irritation of mucous membrane in the throat or ear. He had treated several of these cases most successfully by free incision and enucleation. In some cases this had been before the constitution had given way, and in these the results were brilliant. It was found that under the larger glands often lay lesser ones, these, in turn, leading to some deep-seated, perhaps half cretified "kernel," the unnoted offspring of some long forgotten tonsillar or other irritation. By antiseptic surgery he thus would signify not only certain methods of a special kind, but in a general sense surgical cleansing. For, indeed, in a case attended by Mr. Corrie and himself, the rapid and fatal outburst of miliary tubercle was traced, after death, by Mr. Corrie's industry, to a small suppurating gland in the mesentery, itself, doubtless, a secondary event.

Edison's New Ear Trumpets.

The *Scientific American* says that Professor Edison, in his researches on sound, has made many curious experiments, one of the most interesting of which is that of conversing through a distance of $1\frac{1}{2}$ to 2 miles, with no other apparatus than a few paper funnels. These funnels constitute the megaphone, an instrument wonderful both for its simplicity and effectiveness. Such an instrument stands on the balcony of Professor Edison's laboratory. A mile and a half distant there is another instrument exactly like the first one.

The two larger funnels are 6 feet 8 inches

long, and $27\frac{1}{2}$ inches in diameter at the larger end. These funnels are each provided with a flexible ear tube, the end of which is placed in the ear. The speaking trumpet in the middle does not differ materially from the ordinary ones. It is a little longer and has a larger bell mouth. With this instrument conversation can be readily carried on through a distance of $1\frac{1}{2}$ to 2 miles. A low whisper, uttered without using the speaking trumpet, is distinctly audible at a thousand feet, and walking through grass and weeds may be heard at a much greater distance.

Treatment of Ununited Fracture.

Mr. Fitzgerald, of Australia, in view of the unsuccessful results attained by the milder and severer remedies commonly used in treating this troublesome accident, strongly advocates the injection of glacial acetic acid, 5 to 10 minims, by means of the hypodermic syringe, between the ununited ends of bone. His experience of this method of treatment has been uniformly successful. It is attended by sharp pain at first, but this quickly subsides. Any cartilaginous thickening that may be present is soon resolved and reabsorbed, and bony union takes place rapidly, apposition of the ends of the bone being secured by well applied splints.

Warm or Cold Water in Fevers.

A writer in the Cincinnati *Lancet and Observer* argues strongly against the use of cold water as a beverage in fevers. Warm water is not apt to produce vomiting; it is not taken in immoderate quantities; it does not lower the vital powers; it causes no shock to the system; it quenches thirst more permanently. These points seem well taken and deserve consideration.

The Nature of Syphilis.

Dr. Cornil, of Paris, one of the latest teachers on this subject, insists on the anatomo-pathological differences between soft and hard chancre, the period of incubation being the distinguishing feature. Soft chancre appears immediately after contamination, indurated after a time varying from ten to twenty-five days, and sometimes extending to a longer period, as has been proved by the observations of Langlebert, Rollet, Diday, etc., and the experiments of Wallace, Vidal de Cassia, Waller, and Pellizari. But what takes place between the time of incu-

bation and the appearance of the chancre? Some authors affirm that the individual is contaminated during the period of incubation, the chancre being the local and first manifestation of a general disorder dating from the day of incubation. Others have denied this theory. M. Cornil considers the most probable hypothesis to be that syphilis is not generalized at the onset, but that the chancre is the first complication, which by little and little infects the whole economy.

A Man Who Burst.

We have all of us, in early life, had held up to us as a warning, when too voracious, the terrible story of the boy who ate so much that he burst! The learning of maturer years led us too hastily to discredit this frightful example; for here, in the last number of the *Vierteljahrsschrift, für Gerichtliche Medicin*, July, 1878, Dr. Bremuse gives a detailed account of a man who literally burst, split his diaphragm in two and died, from four plates of potato soup, "numerous" cups of tea and milk, followed by a large dose of bicarbonate of soda to aid digestion! His stomach swelled enormously, and tore the diaphragm on the right side, causing immediate death. The case is probably unique.

A Study of Tremor.

An entertaining article is contributed to the *Archiv der Heilkunde*, for June, by Dr. Paul J. Möbins, on tremor (*das Zittern*). It includes such phenomena as the chattering of the teeth in cold or fright, the tremor of the drunkard, the paralytic, and the aged, that which follows poisoning by lead, arsenic, mercury, etc. The general cause of this species of trembling he is inclined to believe is some disturbance of nutrition in the central nervous organs, connected with hyperæmia or anæmia.

Shooting With Water.

In this country, as well as in Germany, there is a popular belief that a gun loaded with water instead of shot will kill and leave no trace. The subject has been studied by Dr. Edward Hofman (*Wiener Med. Wochenschrift*, No. 7, 1878), who finds that there is, in fact, very little external indication of the actual force of the fluid projectile, but adds that its effect is not so great as generally believed, much of the injury being attributable to the explosion of the powder.

Therapeutical Notes.

PHOSPHATE OF AMMONIUM IN DIABETES MELLITUS.

In a Polish medical journal, Dr. Jentys reports successful treatment of marked diabetes mellitus, with seven to ten per cent. of sugar in the urine, by the administration of about four grammes of phosphate of ammonium daily. The sugar did not wholly disappear, but in other respects the cure was complete.

CHLORAL PLASTER.

This is made by sprinkling pulverized chloral on a Burgundy pitch plaster, one to two grammes on a plaster four inches square. It produces small vesicles when left on twenty-four to forty-eight hours. Its use is praised in lumbago, pleurodynia, intercostal neuralgia, etc.

SULPHATE OF SODIUM IN CHRONIC CARBOLIC ACID POISONING.

The enormous use of carbolic acid in surgery is liable to produce a form of chronic poisoning characterized by nausea, vomiting, headache, and a dark coloration of the urine, and by an absence, in the latter, of sulphates. This can be shown by depriving the urine of its albumen, acidifying it with acetic acid, and adding chloride of barium in excess. Normal urine shows a milky coloring from sulphate of baryta, but in carbolic poisoning this is not perceptible. This fact has led Dr. Sonnenburg to administer, in these cases, full doses of sulphate of sodium, with satisfactory results. His paper is in the *Zeitschrift für Chirurgie*, No. ix.

SALICYLATED OINTMENT IN ECZEMA.

Dr. L. Fleischmann, of Vienna, recommends, in eczema—

| | | |
|----|-----------------|---------------------|
| R. | Acidi salicyl., | grs. xl |
| | Tinct. benzoin, | f. 3ss |
| | Alcoholis, | |
| | Glycerinæ, | aa q. s. ad. solut. |
| | Unguent. emol. | f. 3j. M. |

Sig.—Rub in gently, twice or thrice a day, after washing with soap and water.

Rules for Hypodermic Injections of Morphia.

Dr. H. L. Harrington lays down the following rules, in the *Chicago Medical Journal and Examiner*:—

1. Never use hypodermic injections of morphia except for the relief of intense pain, or where the stomach will not retain the drug.
2. Have a solution accurately prepared, so that the exact amount given is, in every instance, known.
3. As morphia and pain are mutual, an-

tagonistic, and as it is well known that far larger doses are tolerated when pain is present, make the size of the dose proportionate to the severity of pain.

4. Do not leave the patient until sure that no unpleasant effects will follow.

CORRESPONDENCE.

The Opium Habit—No. 2.

ED. MED. AND SURG. REPORTER:—

In considering the matter of cure of the opium habit, let the following points be kept constantly in remembrance: 1. No other drug or combination produces like effects upon the system, therefore nothing else can entirely supply its place. 2. Each preparation of opium possesses its own peculiar power, which differs in a marked degree from the power of every other preparation. For example, if an individual is addicted to the use of morphia, no other preparation of opium, though containing an equivalent quantity of morphia, will supply its place. It will already occur to the reader that opium *must be used* in the cure of the habit; to contend otherwise is evidence of ignorance of the practical phase of the subject. Now, I gradually withdraw the narcotic, but the quantity withdrawn must be compensated for in some way. After years of effort and trial I have discovered that no article will so successfully act this part as *nux vomica*, and that this may be so combined as to be much more effective than the drug alone. I have not the time to notice all the conditions of the opium eater, and the indications to be met, but shall at once indicate my mode of treatment, which, if associated with sufficient will power on the part of the patient, will be successful in every case.

I prepare an elixir, as follows: Dissolve in 96 fl.℥ aqua dest. 10 troy ounces of sodium phos. and 512 grs. val. ammo., then add to the solution 112 fl.℥ dilute phos. acid, and 2 fl.℥ hydrochloric acid. Now, exhaust, by percolation, with stronger alcohol (8 fl.℥), 10.4 grs. pure powdered *nux vomica*, and 160 grs. aromatic powder, U. S. P., driving through the last portions of the menstruum with aq. dest. until it commences to pass cloudy. Mix the percolate with the acid solution of sod. phos.; add to the mixture 16 fl.℥ glycerin, filter through paper, and if the measure is short of one gallon, wash the filter with sufficient distilled water to supply the deficiency.

Though I have been using a similar combination for years, for the above formula I am indebted to Dr. Green, of the firm of Chapman, Green & Co., manufacturing chemists, Grand Crossing, Ill.

Now, how do I use it? Suppose that morphia is the preparation taken. In one pint of the elixir I dissolve the amount of the narcotic taken in one month, less 25 per cent., and

direct my patient to take 5j four times a day. If the quantity taken is immense, say 20 or 30 grs. per diem, or the system is badly shattered, with much digestive trouble, or intestinal apathy, I double the dose of the elixir.

After the first month I reduce the opiate twenty per cent. monthly, and the patient is not aware of the reduction until the quantity of morphia is comparatively small, depending, of course, on the quantity to which the system had been habituated. But, should there be rebellion, it will likely be slight, requiring only will power to subject it. In some cases it may be necessary, toward the close of the treatment, to reduce less rapidly, yet I have never reduced less than twenty per cent. The point at which the narcotic is left out, the pure elixir only being given, will depend on circumstances, such as quantity taken, etc. In case of sleeplessness, a full dose of bromide of potassium or sodium will usually produce quiet and rest. In some cases, perhaps, chloral will be required, but, if so, it must be given only when absolutely necessary. I have never been compelled to resort to it. Another matter I will refer to briefly. It is necessary that the patient be as actively employed as the strength will admit, as idleness and constant thought of the habit will retard the cure. Every physician will understand this. And another thing is necessary. In the beginning of the treatment the victim must be determined to succeed, as each successive effort at redemption will meet with a weakened will power. I have not the time to specify all the details of treatment, but they will naturally be suggested to the intelligent physician. It must be remembered, however, that opium is a powerful agent in producing hallucinations, and much of the difficulty (if not actual pain) experienced can be dissipated by the exercise of a strong will.

In conclusion, I will say to the many physicians who have deluged me with letters, that sickness has prevented me from concluding these articles sooner, and also accounts for the rapid disposal of the subject. If, however, the directions I have given are faithfully followed, the most confirmed opium eater can be redeemed, and be redeemed with ease.

S. W. GOULD, M.D.

Argos, Ind., August 6th, 1878.

Curious Result of a Bee Sting.

ED. MED. AND SURG. REPORTER:—

Permit me to record an interesting case as the result of peculiarity of constitution. The case is that of S. R. M., who was stung by a common honey-bee, July 26th. He came immediately to my office, and I found that he had been stung over the left lobe of the thyroid gland, and that respiration was somewhat interfered with, although but a few moments had elapsed since it had been received. I bathed the parts with aromatic spirits of ammonia, and gave an internal dose, recommending him to go home and keep quiet, as I thought it of small

importance, as we are frequently hearing of, and seeing, persons stung extensively with but transient results. He went home (but a short distance), but only a short time went by when a messenger came, telling me that my patient was growing worse and wanted my assistance. On going to the house the throat was found to be considerably swelled—the internal more than the external parts—there being the peculiar wheal at the point of the sting. His symptoms were not unlike those of croup in the second stage. There was hurried and difficult respiration, attended with a harsh wheeze at expiration as well as inspiration; dry cough and frequent; face swelled and flushed; eyes suffused and bloodshot; dry skin; pulse full and bounding; severe headache; that condition of the skin called *cutis anserina* of both upper and lower extremities; rigors; a "stiffness" of the nose; the tongue-papillæ were prominent already. He was sitting up, and his general appearance indicated general disturbance of the system. The respiration was becoming still more difficult while making these observations, and I saw visions of a possible tracheotomy. Aqua ammonia was applied to the throat, to vesication, and a large, moist, hot cloth applied over the blister. Internally, was given the aromatic spirits of ammonia every half-hour, in half-drachm doses till three doses had been given, and by that time the patient was considerably better. The vesication relieved the difficult breathing in a short time. The rigors ceased, and the *cutis anserina* was displaced by efflorescence. I then gave fifteen minims of the aromatic spirits of ammonia every two hours, with four-grain doses of the sulphate of cinchonidia, alternately; at the same time to drink a strong decoction of melon seed occasionally, as by this time there was some oedema of the tissues of the head and arms, which resulted in a copious diuresis and relief, though much muscular soreness remained for several hours. All his symptoms disappeared in twenty-four hours. Six years ago this same patient was stung on the forearm and was unable for duty for seventy-two hours, with similar symptoms at that time. Under like circumstances I think I would use the same treatment.

W. W. PENNELL, M.D.

Nashville, O., August 11th, 1878.

Galvanic Treatment of the Ulcerated Os Uteri and Vaginal Leucorrhœa.

ED. MED. AND SURG. REPORTER:—

While reading a clinical lecture, published in the MEDICAL AND SURGICAL REPORTER, and reprinted in the *Michigan Medical News*, on the treatment of bed sores and ulcers by galvanism, by Dr. Charles K. Mills, it occurred to me that a similar plan might be pursued in the treatment of ulcerations of the os uteri. Having a patient who had been suffering with a prolapsed and ulcerated uterus for a long time, and to whom I had applied one of the "silver wire and soft rubber" pessaries described in the *Medical*

Record, of July 6th, which simply consists of a soft rubber ring with a silver wire stem, and is attached to a web belt by elastic cords crossing each other through the protruding end of the silver wire stem, which is twisted, to give temper to the silver wire and to form the loop for the elastic cords to pass through, while the wire is drawn tight enough to imbed it into the rubber ring, so that it cannot irritate the uterine neck (I give this brief description of the pessary lest some readers would not understand how the galvanic attachment was made), I conceived the idea of utilizing the silver wire stem to get up a galvanic current, proceeding to effect my purpose in the following manner: 1st, by making a little bag of chamois skin, about two inches long by one wide, and fastening it upon the front of the belt used to sustain the pessary in position. 2d, I then cut a piece of zinc about one inch square, perforated it and attached a small copper wire, the other end of which I attached to the protruding end of the silver wire stem. Then putting the zinc with the wire attached into the chamois-skin bag, into which had already been placed a piece of sponge moistened with vinegar, I had the galvanic apparatus of Dr. Mills applied to ulceration in another location. The application above mentioned was made to my patient, who had been under treatment for about ten days without any perceptible change in the ulceration or leucorrhœa; the only improvement was in the fact that the uterus was being kept in place by the supporter, thus relieving the pain.

In thirty-six hours after the galvanic attachment was made I examined my patient and found healthy granulations instead of the unhealthy ulcer without any evidence of granulations, as it had existed before. I also found that the leucorrhœa had almost entirely stopped, a circumstance which the patient stated had not taken place for a year before. In one week there was neither ulceration nor leucorrhœa, at which time I removed the copper wire and zinc. I left the uterine support on a week longer, to make sure the uterus would remain in place. I then removed it and discharged the patient, well, and she continues to remain so up to this writing, three weeks after the apparatus was removed. I have several other cases that I am treating in the same manner, with ulceration, leucorrhœa, etc., all of whom are doing as well as could be desired. I also believe the galvanism is a great help in restoring the normal tone to the natural supports of the uterus. I have noticed that the patients having displacements and wearing the galvanic attachment dispensed with the aid of the uterine supporter sooner than those who did not. O. E. HERRICK, M.D.

Greenville, Mich., Aug. 3d, 1878.

—Dr. Horace Wardner, of Cairo, Ill., has been appointed superintendent of the Southern Illinois Insane Asylum, at Anna, as the successor of Dr. Barnes, resigned. The appointment is regarded as eminently proper in every respect.

NEWS AND MISCELLANY.

Central Nebraska Medical Society.

This Society has been recently organized, and met at Sutton, August 1st, Dr. J. R. C. Davis, President, in the chair.

Dr. A. O. Kendall, of Clay county, presented an article on diphtheria, which gave rise to an animated discussion.

Dr. Clark, of Clay county, presented a written report of a case of sunstroke, showing a more intimate relation to exist than was formerly supposed between a disturbed electrical state of the atmosphere as a cause of this affection than of excessive heat alone.

Dr. Canfield, of Clay county, made a verbal report of an obstetric case.

Dr. Davis, of Hamilton county, made a verbal report of a case of functional disturbance of the heart, and also that of a portion of retained placenta for the remarkable period of eight months.

The annual inaugural address was delivered by the president, Dr. J. R. C. Davis, on "The Science of Medicine." It was a comprehensive review of the healing art, from the earliest time to the present, showing the rapid strides made the past few years. The address was attentively listened to by a good audience.

MARTIN CLARK, M.D., Secretary.

The Yellow Fever and its Rational Treatment.

The advance of this terrible epidemic has been rapid and justly alarming. New Orleans, Corinth, Grenada, Memphis, Vicksburg, Cairo, Louisville, St. Louis, and Cincinnati, have all cases more or less numerous. The latest advices report hundreds of cases in the above-mentioned towns.

Dr. Greenville Dowell, of Galveston, Texas, has written us to urge upon the profession to adopt the treatment of the disease which he used successfully in several severe epidemics, and which he has described at length in his treatise on the disease. The book will be mailed from this office on receipt of the reduced price, \$2.00.

The Education of the Blind.

John F. Maher, M.S., University of Penna., a teacher of several years' experience, proposes to establish an academy for the education of the blind. The intention is not to supersede existing institutions, but rather to add one more, of a special character, whose aim shall be, 1st, to supply the wants of such as prefer a private school to a public institution. 2d to afford blind persons desiring a higher education suitable opportunities to prepare for college. Superior facilities will be afforded for the study of music. Special attention will be paid to the moral and physical training of pupils and their general correctness of deportment.

Pupils of any age received.

A long familiarity with the blind has convinced Mr. M. that a school of this kind is much needed. The best professional and social references.

For further particulars address JOHN F. MAHER, 1319 Chestnut St., Philadelphia, Pa.

A Real Apostle of Temperance.

Instead of platform howlers, would that we had more such men as Dr. Barnardo, of London. This physician was the first to institute the system of temperance coffee houses. He was able, in the east end of London, to secure a magnificent gin palace and a large shop. They were fitted up in an extremely attractive way, and there the workman escaped the ruinous temptation to drink which had been the curse of this metropolis. One of those coffee palaces, during the year, had realized a sum of £2300, its expenses amounting to £2000. In the mission rooms there were evangelistic addresses, and one might see one of these rooms crowded from end to end with anxious and inquiring auditors, to hear a plain, simple address.

—The *Archiv der Heilkunde*, for June 15th, contains an admirable biographical notice of the late Dr. C. B. A. Wunderlich, the founder of scientific medical thermometry, from the pen of Professor O. Heubner. All who read it must lay it down with a deep respect for the personal character of this profound investigator.

OBITUARY.

DR. CHARLES C. WOODWORTH,

Of East Berkshire, Vermont, died at his residence, on the 5th instant, of consumption, at the early age of thirty-two years. He graduated at Bellevue Hospital Medical College, in 1868, and had already established a promising practice, and won the esteem of the community in which he resided, when the signs of a mortal disease showed themselves. He met the approach of death with Christian calmness.

MARRIAGES.

THROCKMORTON—BENTLEY.—On the 8th instant, at the residence of the bride's parents, by the Rev. T. McK. Stewart, Thomas M. Throckmorton, M.D., of Derby, Iowa, and M. Annie Bentley, of Chariton, Iowa.

DEATHS.

DOSTOR.—At Blakely, Ga., Wednesday evening, August 7th, Batey Dostor, infant son of Dr. B. R. and Mrs. S. E. Dostor, aged 1 month and 2 days.

CUYLER.—On the 25th instant, at the residence of Rev. M. B. Grier, Ridley Park, Susan, daughter of Dr. C. C. Cuyler.

MENABE.—In Woodsville, July 20th, Dr. John McNabb, aged 95 years.

WOODBURY.—On Saturday, August 3d, 1878, at the residence of his uncle, Mr. Henry Burton, Roxborough, Clarence, second son of Dr. Frank and Louie R. Woodbury, and grandson of Mr. Thomas S. Woodbury, aged 2 months and 17 days.